BARBARA BILDER D.M.D.
Prosthetic, Esthetic & Implant Dentistry

NAME _____
LAST FIRST MIDDLE DATE

Dental Insurance Information:
Subscriber Name _____ Subscriber's Employer Name _____
Insurance Co. Name_____ Phone _____
Address _____
City_____ State _____ Zip _____ Group Number _____

Please circle YES or NO:

1. Are you presently in pain?..... **YES NO**
   Teeth ____ Jaw ____ Face ____ Gums ____
2. Is any part of your mouth sensitive? ..... **YES NO**
   Hot ____ Cold ____ Sweet ____ Pressure ____
3. Have you ever had periodontal treatment or gum surgery? **YES NO**
   .....
4. Have you ever been informed that you have gum problems? ..... **YES NO**
5. Do your gums bleed when you brush your teeth? ..... **YES NO**
6. Are you aware of a bad taste or odor in your mouth? ..... **YES NO**
7. Do you have frequent headaches and/or neck aches? ..... **YES NO**
8. Do you have ear pain or pain in front of the ears? ..... **YES NO**
9. Does your jaw make popping, clicking, or grating noises? ..... **YES NO**
10. Have you noticed yourself clenching your teeth during the day? ..... **YES NO**
11. Have you been told that you grind your teeth during the night? ..... **YES NO**
12. Does your jaw hurt when you open your mouth wide or take a big bite? ..... **YES NO**
13. Have you ever had your teeth ground to improve your bite? ..... **YES NO**
14. Are you dissatisfied with the appearance of your teeth? ..... **YES NO**
    If YES, what would you most like to change? _____
    _____
15. Have you ever had an unfavorable reaction from local anesthetic?..... **YES NO**
    (Novacaine, etc.)? If YES, explain _____
16. Have you ever had any trouble with any previous dental treatment?..... **YES NO**
    If YES, explain _____
17. Does dental treatment make you nervous? ..... **YES NO**
    If YES, check: _____ Slightly _____ Moderately _____ Extremely

Please indicate which items you use daily for oral hygiene:

___ Hard-bristle toothbrush ___ Soft-bristle toothbrush ___ Electronic toothbrush ___ Proxi-brush
___ Stimudents/Toothpicks ___ Dental Floss ___ Water spray ___ Other

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